STATE OF WASHINGTON DSHS
MEDICAL ASSISTANCE ADMINISTRATION

ACS EDI SUBMITTER ENROLLMENT FORM
INSTRUCTIONS

Please use the following instructions when completing the ACS EDI Submitter Enrollment Form

Section 1. Classification
Please indicate whether you are a Software Vendor, Billing Agent or Clearinghouse. **This field is required.**

Section 2. Submission Method
Please indicate how you will be submitting your electronic transactions. **These fields are required.**

Section 3. Submitter Information
Please complete the appropriate submitter information. **These fields are required.**
Your email address is optional and will be kept confidential.

Section 4. Submitter/Trading Partner ID Number
If you are currently submitting electronic transactions, please indicate your 7-digit Submitter ID **OR** 6 or 7-digit Trading Partner ID.

Section 5. Software Vendors Only
If you are a software vendor, please complete this section. **These fields are required.**

Section 6. Contact Information
Please indicate specific contact person and additional contact information, if different from the submitter information in Section 3 above.

Section 7. Transactions Available for Transmission
If you will be using the WINASAP2003 product, please complete section 7a. If you will be submitting electronic transactions other than WINASAP2003 submissions, please complete sections 7b - 7f.

Sub-Section 7a. WINASAP2003 Transactions
Request for software: Please indicate how you would like to receive the WINASAP software. Also, please indicate which transactions you will be submitting.

Sub-Sections 7b and/or 7d. Asynchronous Transactions
If you will be submitting transactions other than WINASAP2003 or Web Portal transactions, please complete these sections. **Submitters submitting through a Software Vendor must complete these sections.**

Sub-Sections 7c, 7e, and/or 7f. Web Portal Transactions
Sub-sections 7c, 7e, and 7f list the Web Portal transactions that will be available. If you will be submitting transactions other than WINASAP2003 or Asynchronous transactions, please complete these sections where appropriate.

Section 8. Delimiter Information

If you will be submitting X12N transactions directly to ACS, please indicate the alternate delimiter to be used if you are not using the default. **WINASAP2003 users do not need to complete this section.**

Section 9. Electronic Response Retrieval.

Washington Medicaid Submitters will be able to retrieve responses via the Host Data Exchange (HDE). If you would like to participate in this service, please indicate which responses you would like to retrieve via HDE.

If you are a Billing Agent or Clearinghouse and will be retrieving responses on behalf of your clients, please indicate the appropriate X12 responses.

If you are a Software Vendor and plan to format your software for retrieval of X12 responses please indicate the appropriate X12 responses.

Requirement for Washington Medicaid Vendors, Billing Agents, or Clearinghouses:
Due to HIPAA Privacy Regulations, ACS will not be able to accept lists of providers from Vendors, Billing Agents, or Clearinghouse.

Your providers will be required to supply the Trading Partner ID of their Vendor, Billing Agent, or Clearinghouse on their enrollment forms. Please be prepared to supply this information to your providers upon request.

Note to Billing Agents and Clearinghouse

Your providers are required to re-enroll and must indicate that you are submitting on their behalf. We have supplied the *Provider ACS EDI Gateway Authorization Form For Billing Agents/Clearinghouses* in this packet for distribution to your client community. This form is completed by the provider and must be signed and dated by the provider or their representative. The *Provider ACS EDI Gateway Authorization Form For Billing Agents/Clearinghouses* authorizes a billing agent/clearinghouse to submit and/or retrieve transactions on behalf of the provider.

Scenarios are listed below to ensure that the proper documentation is completed by the appropriate party.

> If a provider allows a billing agent/clearinghouse to submit transactions on their behalf, but the provider wishes to retrieve their own responses, including the 835 Remittance Advice, the *ACS EDI Submitter Enrollment Form must be* completed by the submitter and the *Provider ACS EDI Gateway Authorization Form For Billing Agents/Clearinghouses* must be completed by the provider.

If a provider allows a billing agents/clearinghouses to submit and retrieve on their behalf, the *Provider ACS EDI Gateway Authorization Form For Billing Agents/Clearinghouses* is to be completed by the provider.

The *Provider ACS EDI Gateway Authorization Form for Billing Agents/Clearinghouses* follows the *ACS EDI Submitter Enrollment Form* in the attached document.

Instructions for completing the *Provider ACS EDI Gateway Authorization Form For Billing Agents/Clearinghouses*

The *Provider ACS EDI Gateway Authorization Form For Billing Agents/Clearinghouses* must be completed in its entirety and must include the signature of the provider or the provider's representative.

Section A. Provider Information

The Provider must indicate the classification. This is required.
The email address of the provider is optional and will be kept confidential.

Section B. Authorization Signature (required)

The provider must complete the appropriate information. If the provider also authorizes a billing agent/clearinghouse to retrieve electronic responses on their behalf, the provider must check the responses that apply.

The provider or the provider's representative must print their name, sign their name, and date the form.

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ACS EDI SUBMITTER ENROLLMENT FORM

Please print or type. Complete all areas of the Submitter Enrollment Form, unless otherwise indicated.

Section 1. Classification

Please indicate your classification.

☐ Software Vendor ☐ Billing Agent ☐ Clearinghouse

Section 2. Submission Method

Please Indicate how you plan to submit your electronic transactions.

☐ Asynchronous (Direct submission to ACS EDI Gateway, Inc.) ☐ WINASAP2003 ☐ Web Portal

Section 3. Submitter Information

Business Name (If applicable)
Submitter Name (Last, First, MI, and Suffix)
Business Street Address
City, State, and Zip Code

Telephone *( )*	*Fax* *( )*

Email Address

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Section 4. Submitter/Trading Partner ID Number	
If you are currently submitting electronic transactions directly to ACS EDI Gateway, please indicate your seven-digit Submitter ID **OR** six or seven-digit Trading Partner ID:	☐☐☐☐☐☐☐

Section 5. Software Vendors Only					
If you have indicated that you are a Software Vendor in Section 1, please provide the following information:					
Software Name:		Software Version:		Protocol:	
Do you currently have clients submitting to ACS EDI Gateway?	☐ Yes	☐ No			

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Section 6. Contact Information Please indicate contact information.	
Contact Name	*Contact Title*
Business Street Address	
City, State, and Zip Code	
Telephone	*Fax*
Email Address	
Additional Contact Information	
Contact Name	*Contact Title*
Business Street Address	
City, State, and Zip Code	
Telephone	*Fax*
Email Address	

Please attach additional sheets if necessary.

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Section 7. Transactions Available for Transmission	
Sub-Section 7a. WINASAP2003 Transactions (Available October 2003)	
Request for free WINASAP2003 Software: ☐ I will download a copy from the ACS website at www.acs-gcro.com. ☐ Please mail me a CD-ROM of the WINASAP2003 software.	
☐ X12N 837P (Professional Claim)	☐ X12N 837D (Dental Claim)
☐ X12N 837I (Institutional Claim)	
Sub-Section 7b. Asynchronous Dial-Up Batch Transactions (Available October 2003)	
☐ X12N 837P (Professional Claim)	☐ X12N 270 (Eligibility Inquiry))
☐ X12N 837I (Institutional Claim)	☐ X12N 834 (Benefit Enrollment)
☐ X12N 837D (Dental Claim)	
Sub-Section 7c. Web Portal Transactions (Available October 2003)	
☐ X12N 837P (Professional Claim Batch submission only)	☐ X12N 270 (Eligibility Inquiry – Batch)
☐ X12N 837I (Institutional Claim Batch submission only)	☐ X12N 270 (Eligibility Inquiry – Interactive)
☐ X12N 837D (Dental Claim Batch submission only)	☐ X12N 834 (Benefit Enrollment- Batch)
Sub-Section 7d. Asynchronous Dial-Up Batch Transactions (Available January 2004)	
☐ X12N 276 (Claim Status Inquiry)	☐ X12N 820 (Premium Payment - Batch)
☐ X12N 278 (Prior Authorization)	☐ X12N 835 (Healthcare Claim Payment/Advice-Batch)
Sub-Section 7e. Web Portal Transactions (Available January 2004)	
☐ X12N 276 (Claim Status Inquiry – Interactive)	☐ X12N 820 (Premium Payment - Interactive)
☐ X12N 278 (Prior Authorization- Interactive)	☐ X12N 835 (Healthcare Claim Payment/Advice-Interactive)
	☐ X12N 277U (Unsolicited Claim Status)

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Sub-Section 7f. Web Portal Transactions (Available June 2004)	
☐ X12N 837P (Professional Claim- Interactive)	☐ X12N 837D (Dental Claim- Interactive)
☐ X12N 837I (Institutional Claim - Interactive)	☐ X12N 277U (Unsolicited Claim Status)

Section 8. Delimiter Information If you are submitting X12N transactions directly to ACS, please provide the following information. **(This information is not required if you are using WINASAP2003).**

Element Delimiter to be used:	**Segment Delimiter to be used:**	**Sub-Element Delimiter to be used:**
Default Delimiter (asterisk) * ☐	*Default Delimiter (tilde)* ~ ☐	*Default Delimiter (colon)* : ☐

Section 9. Electronic Response Retrieval

Washington Medicaid Submitters can retrieve their electronic responses from The Host Data Exchange (HDE). If you would like to participate in this service, please complete the section below. For more detailed information regarding electronic Remittance Advices, please see the 835 Companion Guide located on the ACS website at www.acs-gcro.com.

Responses Available for X12N Transactions – check all that apply:	
☐ X12N 997 (Functional Acknowledgement)	☐ X12N 820 (Premium Payment)
☐ X12N 271 (Eligibility Response)	☐ X12N 834 (Benefit Enrollment)
☐ X12N 278 (Prior Authorization)	☐ X12N 835 (Healthcare Claim Payment/Advice)
☐ X12N 824 (Error Report)	☐ X12N 277 (Claims Status Response)

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Provider ACS EDI Gateway Authorization Form For Billing Agents/Clearinghouses

Section A. Provider Information

Please indicate your classification (***Required***): ☐ Individual Provider ☐ Group Provider/Practice	
Business Name	
Provider Name (Last, First, MI and Suffix)	
Provider Number (Required for Individuals)	*Group Provider Number (Required for Groups)*
Business Address	
City, State, and Zip	
Telephone Number	*Fax Number*
Contact Name	*E-mail Address*

Section B. Authorization Signature *(Required)*

Provider, _____ hereby appoints
Provider name /Provider Representative name (please print)

_____, _____
Billing Agent/Clearinghouse name (please print) *Billing Agent/Clearinghouse ACS Trading Partner/Submitter ID*

to act as the authorized agent for the purpose of submitting health care transactions electronically to ACS EDI Gateway, Inc.
Provider also authorizes the Billing Agent/Clearinghouse's access to the following X12N transaction responses if selected below:

☐ 271-Eligibility Response ☐ 277-Claims Status Response ☐ 278-Prior Authorization Response
☐ 824-Error Report ☐ 834-Benefit Enrollment ☐ 835-Healthcare Claims Payment Advice

_____
Provider/Provider Representative name (Please print)

_____ _____
Provider/Provider Representative Signature *Date*